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### **Patients of 21st Century Require New Form of Care**

Almost half of all Americans, 133 million people, live with a chronic health condition. Those 133 million are equally divided among the elderly, working-age adults and children. Care of chronic illness accounts for 75 percent of all U.S. health expenditures. Yet the traditional health care system— designed for short episodes of acute illness— is poorly designed to meet the needs of people with chronic health conditions. The misdirected cry for "market forces" will not solve underlying design flaws.

Americans with chronic health conditions, and aging baby boomers in particular, are surrounded by health care systems that require fundamental redesign. Relevant solutions are emerging in new care models for chronic illness. We have successful examples close to home.

Researchers in the large Dartmouth Atlas Project, with primary funding from Robert Wood Johnson Foundation, can now compare the treatment of Medicare patients with chronic illness across different states, regions, hospitals and physicians. Ongoing study indicates serious problems with quality of care and dramatic variations in practice.

The Dartmouth Atlas Project hopes to end a "more is better myth." In chronic illness care, greater use of medical resources is associated, if anything, with worse outcomes, poorer quality and lower satisfaction with care. More than 30 percent of Medicare dollars are spent on the last two years of life, when available hospital beds become the path of least resistance, and high-tech rescue attempts and aggressive treatments are thrown at illnesses that will not improve, robbing patients of a dignified end of life.

Most people receive episodic care from multiple physicians who may or may not coordinate care. High numbers of patients and informal caregivers lack needed information and are too often excluded from decision making. The medical record is chopped into pieces across multiple providers. Many patients lack a "medical home", a primary care physician who keeps track of the multiple specialists that may be involved in one patient's care. New solutions must carry the seeds of health care prior to the intrusion of technology; a recasting of the family doctor model in which relationships with primary providers extend beyond episodes of care.

When patients age 25 and older have a primary care medical home rather than a specialist as a personal physician, costs are lowered by 33 percent. When patients have more participation in care decisions, "both the costs and the rate of expensive and invasive surgeries tend to fall and outcomes and satisfaction improves." New biomedical advances may hold hope for some, but it is more likely the work of hospice and palliative care models focused on supportive care hold the answers to better health outcomes and greater patient satisfaction for Americans challenged by chronic health care conditions.

Washington state has successful examples of care for chronic illness. Locally, the Providence St. Peter Family Medicine Clinic participated in a successful demonstration grant for self-managed diabetic care. Group Health Cooperative's MacColl Institute has emerged as a national leader in chronic care models. In Whatcom County, a "Pursuing Perfection" grant allowed providers to improve care for both diabetes and heart failure patients using shared care plans and services redesigned by multi-organization care teams. These new methods offer a glimpse of a revitalized health system, ready to respond to our long lives and the vulnerability of daily life with illness.